Statement to the Nationwide Health Information Network Working Group
Directory Services at the Social Security Administration
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Good morning. I'm Jim Borland, Special Advisor for Health IT at the Social Security Administration (SSA). I'm pleased to be here today to provide testimony on SSA's current practice of using agency-created federal and state vendor files to identify and request evidence from medical sources, as well as its future vision and support for the creation of a single, authoritative directory of providers of medical records.

SSA is the nation's single largest provider of long-term disability benefits. Currently, SSA's two federal disability programs provide roughly $15 billion in monthly cash benefits, which are based on the presence of a disability, to almost 15 million OASDI and SSI beneficiaries. A roughly comparable amount of Medicare and Medicaid benefits is also paid out to health care providers on behalf of those beneficiaries.

To determine the eligibility of the nearly 3 million people who apply for these benefits each year, SSA must obtain and review their relevant medical records. In connection with that review, SSA makes more than 15 million patient-authorized requests to the nation's 500,000 doctors, clinics, hospitals, and other treating sources.

We also are proud to say that with our partner, MedVirginia, we are among the first to use the Nationwide Health Information Network (NHIN) to securely request and receive medical records. The availability of the NHIN means that our medical records requests, which typically require weeks or even months to fulfill, are responded to by participating clinicians of the MedVirginia network in seconds. The results of this use of health IT are incontrovertible—where health IT-gathered medical records are present, average case processing time is cut almost in half.

This use of health IT to gather medical records is groundbreaking. But it is not without its challenges. Today, we use a home-grown national provider directory that we call the Source Reference File. It is a conglomeration of 54 State Vendor Files. It is used for purposes as diverse as records requests and records payments. It is updated at the state and federal levels. Because of this, it contains duplicates, aliases, misspellings, incomplete and out-of-date information. For example, in the case of Beth Israel Deaconess Medical Center (BIDMC), where we have 4 facilities that use health IT to share records with us, the Source Reference File contains over 1200 entries. While we have cross referred these entries to the electronic health record end point for BIDMC, it is a manual process that must be constantly monitored.

As we move forward to expand the use of health IT to gather medical records, we recognize that the current model is unsustainable. So, over a year ago, we began work on a national provider directory to support both our health IT efforts and our planned consolidation of 54 State Disability Determination Services systems into a single,

national system that we call the Disability Case Processing System. Among the foundational requirements for the national provider directory are standard identification information for all of the nation's clinical professionals and medical records location, fax number, e-mail address, electronic health record end point and preferred response method (mail, fax, Electronic Records Express or HIT) for each.

So, you can see from those requirements that our needs are far from unique. SSA and other NHIN participants have a common need for an authoritative directory of medical providers to facilitate interoperability and support electronic communication and data exchange.

The objective is to be able to easily identify providers and determine whether they are participants on the NHIN. For NHIN participants, the directory should identify clinical relationships and affiliations and provide addressable electronic endpoints for the request of medical evidence. For non-participants, we will know to trigger a request for medical records in a manner other than through our health IT system, by mail or fax, for example.

The value proposition of a unified registry is not unique to SSA. With the increased focus on health IT and adoption of electronic health records, there becomes the clear need for an authoritative means of identifying healthcare providers and understanding their relationships. To that end, SSA recently submitted a proposal to the Integrating Healthcare Enterprise (IHE) committee in order to raise interest among the IHE members and in an attempt to gain partnerships in pursuance of a provider registry. The cornerstone of that proposal was a common look-up interface, a "411" for health care providers.

We look forward to working collaboratively with this working group and other stakeholders to help define the requirements for a provider registry. We also understand that we are in a unique position to help frame these requirements. As the first federal agency to participate in the live exchange of medical information through the NHIN, and with our planned expansion efforts in 2010, we might serve as a test-bed for electronic exchange facilitated by an authoritative provider registry. We are currently in discussion with the Office of the National Coordinator to determine if and how we might best assist in this regard.

Thank you again for the opportunity to testify on this vital issue. I have invited two of Social Security's technical experts on provider directories—Marty Prahl and Shanks Kande--to join me today. We would be happy to answer your questions.